

EXAMPLE

(Facility Name)

PNEUMOCOCCAL IMMUNIZATION HISTORY

Date_____

Name_____

Date of Birth_____

Have you ever had a Pneumococcal vaccination? ____YES ____DATE
____NO ____UNSURE

MAY WE CHECK WITH YOUR PHYSICIAN TO DETERMINE YOUR
IMMUNIZATION STATUS? ____YES ____NOT AVAILABLE

UPON REVIEW WITH DR. _____, RESIDENT'S RECORDS
INDICATE PNEUMOVAX WAS/WAS NOT GIVEN _____DATE

EXAMPLE

(Facility Name)

PNEUMOCOCCAL IMMUNIZATION INFORMED CONSENT

Pneumococcus is an illness caused by bacteria, affecting people of all ages. Individuals with pneumococcus may have fever, chills, mucus production, chest pain that increases with breathing, pneumonia, confusion and changes in level of consciousness. Complications can lead to death. Vaccination is strongly recommended for all individuals 65 years of age or older, those with chronic health problems, and residents of extended care facilities and facility staff. Revaccination varies depending on age and other factors. Those vaccinated prior to age 65, with chronic disease, should be revaccinated at age 65 if >5 years have elapsed since the previous dose. This vaccine may not protect you from contracting pneumococcus, but it can reduce the severity of the illness and help prevent complications.

As the resident or responsible party, I hereby give my permission for the facility to administer a pneumococcal vaccination, per my physician's order. To the best of my knowledge, I/resident have not had a serious allergic response to previous pneumococcal immunization. I understand that pneumococcal vaccine, like any medication, is capable of causing serious problems such as severe allergic reaction. The risk is extremely small. I have been instructed that as a result of the vaccination I may experience the following side effects:

- ~slight discomfort at the site of injection
- ~fever
- ~general sense of being unwell

These side effects are generally mild and may last 1-2 days. Potential side effects have been explained to my satisfaction.

Signature of Resident/Responsible Party

Date

Signature of Witness

Date

I, as the resident or responsible party, do not wish to receive the pneumococcal vaccination.

Reason_____

Signature of Resident/Responsible Party

Date

Signature of Witness

Date